3 Long-Term Care Facility Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided through the Long-Term Care Facility Program as deemed appropriate by the Department of Health and Welfare. It addresses the following:

- Claims payment
- Electronic claims billing
- Paper claims billing
- Covered services
- Leave of absence (LOA)
- Level of care revenue codes

Note: Long-term care services are covered for Medicaid Enhanced Plan participants.

3.1.2 Advance Directives

Long-term care providers must explain to each participant their right to make decisions regarding their medical care, which includes the right to accept or refuse treatment. Long-term care providers will inform the participant of their right to formulate advance directives, such as a living will or durable power of attorney for health care at the time of the participant's admission as a resident.

3.1.3 Customary Fees

Medicaid reimburses long-term care services on a *per diem* rate basis. A separate rate is assigned to each facility.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, certain guidelines must be followed to ensure reimbursement for providing Medicaid covered services. See *Section 1.5 Healthy Connections (HC)* of the *General Provider and Participant Information Guidelines,* for more information.

Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR) require prior authorization (PA) from Regional Medicaid Services (RMS) that obtains the referral from the primary care provider (PCP). No referral number is required on the billing form.

3.1.3.1 Retrospective Rate Increases or Decreases

Idaho Medicaid reimburses claims at the lower of the billed amount or Medicaid allowed amount; therefore, nursing facilities should always bill their usual and customary charges, rather than the Medicaid allowed per diem.

When there are retrospective rate increases or decreases for nursing facilities, the adjusted rates are added to the system and DHW initiates mass adjustments to previously paid claims for that facility for the time period that the rates have been adjusted.

If the original claim was billed at the Medicaid allowed amount and the rate is increased retrospectively, the adjusted claim will pay at the original billed amount so the provider will not receive additional reimbursement.

3.1.4 Covered Services

Legend drugs, physician services, and certain other costs are paid directly by DHW and separately from other long-term care payments. Otherwise, the *per diem* rate includes all medically necessary long-term care services including nursing services, room and board services, therapies, over-the-counter medications, social services, activities, and such other services required as a condition of facility certification.

3.1.4.1 Special Rates

Special rates may be requested to pay for care given to participants who have long-term care needs beyond the normal scope of facility services. The payments for such specialized care will be in addition to any payments made to the facility. To request a special rate, contact the Bureau of Long-Term Care for an Idaho Nursing Facility Special Rate Request form to fill out and return for approval. The Department of Health and Welfare will notify the facility if its special rate request is approved or denied.

3.1.5 Swing Bed General Policy

For those hospitals that meet the Code of Federal Regulation (CFR) requirements and are approved by Centers for Medicare and Medicaid Services (CMS) to provide swing-bed care, a separate NF provider number is needed for reimbursement from the Medicaid program.

3.1.5.1 Reimbursement

The Department of Health and Welfare will reimburse hospital swing-beds on a *per diem* basis for participants eligible for a nursing home level of care. Medicaid Policy establishes rates annually by March 15 of each calendar year, to be effective January 1 of the respective year. Revenue code **100** will be used to bill for swing bed patient days. Hospitals are required to apply for a long-term care provider number in order to bill for swing-bed days. Hospitals cannot bill for swing-bed days under their hospital provider numbers.

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type **131**) and settled on a cost basis with other outpatient services. The swing bed rate includes the same services that are included in the nursing facility *per diem* rate outlined in *IDAPA 16.03.10.225 Nursing Facility Services – Coverage And Limitations*.

Note: Prescription drugs must be billed on the outpatient pharmacy claim form.

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3.2 Long-Term Care Service Policy

3.2.1 Overview

Long-term care services include nursing services, room and board services, therapies, over-the-counter medications, social services, activities, and such other services required as a condition of facility certification.

Note: Long-term care services are covered for Medicaid Enhanced Plan participants.

3.2.2 Leave of Absence (LOA)

An LOA occurs when a participant goes on a temporary leave of absence from the facility, such as to the hospital or home.

A day may not be billed when a participant is on a non-covered leave of absence to home, in the hospital, or is not otherwise incurring a billable Medicaid day.

When a long-term care patient residing in a NF (not in an ICF/MR) goes on LOA to home, the facility may be eligible for a reserve bed payment if the facility charges private paying patients for reserve bed days. Therapeutic home visits for other than ICF/MR residents of up to three days per visit and not to exceed a total of 15 days per calendar year so long as the days are part of a treatment plan ordered by the attending physician. Eligibility for reserve bed payment is determined by DHW for non-ICF/MR participants.

If the LOA is for longer than 3 days, written authorization must be obtained in advance from the nurse reviewer in the RMS and a copy attached to the UB-04 claim form. If a participant is discharged after 3:00 p.m. the provider may submit charges for that day. Payment for reserve bed days is the lesser of 75 percent of the NF rate or the customary charge.

Participants of ICFs/MR are allowed up to 36 LOA days to home per calendar year so long as the days are part of a written treatment plan ordered by the attending physician. Prior authorization from the RMS must be obtained for any home visits exceeding 14 consecutive days. Payment for reserve bed days is 100 percent of the facility rate for ICF/MR patients. Regulations addressing LOA payments are listed in *IDAPA 16.03.10.292 Nursing Facility – Payments For Periods Of Temporary Absence*.

3.2.3 Long-Term Care Revenue Codes

Use the following revenue codes in field **42** of the UB-04 claim form or in the appropriate field of the electronic claim form, to indicate the level of care:

100 Inpatient days (NF, ICF/MR, or swing bed)

183 LOA (NF therapeutic leave to home)

184 LOA (ICF/MR therapeutic leave to home)

3.2.4 Third Party Insurance and Medicare Crossovers

3.2.4.1 Third Party Recovery (TPR)

For participants with other nursing home insurance coverage, providers must bill the other insurance(s) prior to billing Idaho Medicaid. An explanation of benefits (EOB) from the other insurance is required with each Medicaid claim submission.

Note: An EOB from a primary insurance that does not include long-term care coverage will not be required.

3.2.4.2 Medicare Crossovers

Part B Medicare claims will automatically cross over from Medicare to Medicaid when the provider takes assignment.

Long-term care services that have been paid by Medicare Part B will cross over to Medicaid for payment when there is a deductible or coinsurance amount due for those services. Medicare Part A claims do not automatically cross over from Medicare. These claims must be submitted on paper with the Medicare EOB attached, or billed electronically without an attachment if the provider's software allows it.

Examples of some of these services covered by Part B Medicare are physical therapy, certain medical supplies, and liquid nutrition when it is one hundred percent of the participant's nutritional intake. Always submit the total charges billed to Medicare, not just the allowed amount.

See *General Billing, Section 2.4 Third Party Recovery (TPR)*, for more information.

3.2.5 Participant Liability or Resource Amount

Enter the participant resource amount in field **39** on the UB-04 claim form or in the appropriate field of the electronic claim form. Enter the amount most recently available. If the amount is later determined to be different, submit an adjustment. Correcting a resource amount cannot be accomplished on a subsequent claim.

Idaho Medicaid does not accept more than one patient liability record with a value code of **31**. Field **39 a-d** of the UB-04 claim form should have the value code of **31** listed only once with a total of the patient liability listed. Do not break out the patient liabilities.

3.2.6 Adjustments

Send all long-term care facility adjustments to EDS. Only a paid claim can be adjusted. EDS cannot adjust a denied or pended claim. See *Section 2.6 Adjustments,* for instructions on how to complete the Adjustment Request form or electronically void and replace the claim.

Form Available: An Adjustment Request form with detailed instructions is included in *Appendix D; Forms*.

Mail to:

EDS
PO Box 23
Boise ID 83707

3.2.7 Type of Bill Codes

The type of bill is a 3-digit code indicated in field **4** of the UB-04 claim form or in the appropriate field of the electronic claim form. The first 2-digits are always **21**. The last digit depends on the type of claim billed:

211 Admit through discharge

212 Interim, first claim

213 Interim, continuing claim

214 Last claim

215 Late charges only

3.2.8 Patient Status Codes

The patient status code is indicated in field **17** of the UB-04 claim form or in the appropriate field of the electronic claim form.

01 Discharge to home

02 Transfer to hospital

03 Transfer to long-term care facility

04 Transfer to state hospital

05 Discharged to another type of institution for inpatient care or referred for outpatient services

06 Discharge/transfer to other (Indicate in field **80** of the UB-04 claim form or in the appropriate field of the electronic claim form, the status or location of the participant and the time they left the long-term care facility)

07 Left against medical advice

08 Discharged/transferred to home under care of a home IV provider

20 Death

30 Not discharged, still a patient

40 Expired at home

41 Expired in an institution

42 Expired, place unknown

3.2.9 Admission Code for Long-Term Care

Code	Type	Description
3	Elective	The participant's condition permits adequate time to schedule the availability of a suitable accommodation.

3.2.10 Source of Admission Codes

Code	Name	Description
1	Physician Referral	The participant was admitted to this facility upon recommendation of his/her personal physician.
2	Clinic Referral	The participant was admitted to this facility upon recommendation of this facility's clinic physician.
3	HMO Referral	The participant was admitted to this facility upon the recommendation of a health maintenance organization physician.
4	Transfer from a Hospital	The participant was admitted to this facility as a transfer from an acute care facility where he/she was an inpatient.
5	Transfer from a Nursing Facility or Skilled Nursing Facility	The participant was admitted to this facility as a transfer from a nursing facility or skilled nursing facility where he/she was an inpatient.
6	Transfer from Another Health Care Facility	The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility, a nursing facility, or skilled nursing facility. This includes transfers from ICF/MR long-term care facilities.
7	Emergency Department	Not applicable to long-term care facilities.
8	Court/Law Enforcement	The participant was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.

3.2.11 Admission Hour Codes/Discharge Hour Codes

00 - 12:00 (midnight) - 12:59 a.m.

01 - 01:00-01:59 a.m.

02 - 02:00-02:59 a.m.

03 - 03:00-03:59 a.m.

04 - 04:00-04:59 a.m.

05 - 05:00-05:59 a.m.

06 - 06:00-06:59 a.m.

07 - 07:00-07:59 a.m.

12 - 12:00 (noon) - 12:59 p.m.

13 - 01:00-01:59 p.m.

14 - 02:00-02:59 p.m.

15- 03:00-03:59 p.m.

16 - 04:00-04:59 p.m.

17 - 05:00-05:59 p.m.

18 - 06:00-06:59 p.m.

19 - 07:00-07:59 p.m.

08 - 08:00-08:59 a.m.
09 - 09:00-09:59 a.m.
10 - 10:00-10:59 a.m.
11 - 11:00-11:59 a.m.
20 - 08:00-08:59 p.m.
21 - 09:00-09:59 p.m.
22 - 10:00-10:59 p.m.
23 - 11:00-11:59 p.m.
99 - Hour Unknown

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

- To submit electronic claims, use the HIPAA compliant 837 transaction.
- To submit claims on paper, use original red UB-04 claim forms available from local form suppliers.

All claims must be received within 12 months (365 days) of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See *Section 2.2.1 Electronic Claims Submission,* for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional transactions.

Surgical Procedure Codes – ICD-9-CM Volume 3: Idaho Medicaid allows 25 surgical procedure codes on an electronic HIPAA 837 Institutional transaction.

Modifiers: On an electronic HIPAA 837 Institutional transaction, where revenue codes require a corresponding HCPCS or CPT code, up to four modifiers are allowed. (On a paper claim, only two modifiers are accepted.)

Revenue codes, requiring a corresponding CPT/HCPC procedure code which is broken into professional and technical components, require the appropriate modifier. For institutional claims, the **TC** modifier must be submitted.

Type of Bill (TOB) Codes: Idaho Medicaid rejects all electronic transactions with type of bill (TOB) codes ending in a value of six. Electronic HIPAA 837 Institutional transactions with valid TOB codes, not covered by Idaho Medicaid, are rejected before processing.

Condition Codes: Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional transaction.

Value, Occurrence, and Occurrence Span Codes: Idaho Medicaid allows 24 value, 24 occurrence, and 24 occurrence span codes on the electronic HIPAA 837 Institutional transaction.

Diagnosis Codes: Idaho Medicaid allows 27 diagnosis codes on the electronic HIPAA 837 Institutional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes:
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for institutional services.

3.3.3 Guidelines for Paper Claim Forms

3.3.3.1 How to Complete the Paper Claim Form

These instructions support the completion for the UB-04 claim form. The following will speed claim processing:

- Provider numbers submitted on the paper UB-04 claim form must be the 9-digit Idaho Medicaid billing provider number; paper claims submitted with only the NPI will be returned to the provider; claims submitted with both the NPI and the Medicaid provider number will be processed using the Medicaid provider number only.
- Complete all required areas of the UB-04 claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning.
- Keep claim form clean, use correction tape to cover errors.
- A maximum of 22 line items per claim can be accepted; if the number of services performed exceeds 22 lines, prepare a new claim form and complete the required data elements; total each claim separately.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- Do not use staples or paperclips for attachments, stack them behind the claim.
- Do not fold the claim form(s), mail flat in a large envelope (recommend 9 x 12).

See Section 3.3.4.3 *Completing Specific Fields on a Paper Claim Form,* for instructions on completing specific fields.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on a Paper Claim Form

See *Section 3.3.4.4 Sample Claim Form*, to see a sample UB-04 claim form with all fields numbered. Provider questions regarding institutional policy and coverage requirements are referred to *IDAPA 16.03.09 Medicaid Basic Plan Benefits and 16.03.10 Medicaid Enhanced Plan Benefits.*

The following numbered items correspond to the UB-04 claim form. Consult the, Use column to determine if information in any particular field is required and refer to the, Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Unlabeled Field	Required	Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA). **Note:** If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.
3a	PAT. CNTL #	Desired	The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of patient financial records.
3b	MED REC #	Desired	Medical/Health Record Number: The number assigned to the participant's medical/health record.
4	TYPE OF BILL	Required	Type of Bill: Enter the 3-digit code from the *UB-04 Manual*. Adjustment Type of Bill Codes are not appropriate when submitting services on paper claim forms for Idaho Medicaid billings. See *Section 3.2.7 Type of Bill Codes*.
6	STATEMENT COVERS PERIOD	Required	Statement Covers Period From/Through: The beginning and ending service dates of the period included on the bill. Enter as MMDDYY or MMDDCCYY
8a	PATIENT NAME - ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. If this field is empty, the system will default to field **60**. Example: 0234567 can be entered as 02345670000.
8b	PATIENT NAME	Required	Patient Name: Enter the participant's name exactly as it is spelled on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
12	ADMISSION DATE	Required	Enter the month, day, and year the participant entered the facility. (This date will be the same on all submitted claims and will not necessarily be the same as the date found in field **6**. Enter as MMDDYY or MMDDCCYY
13	ADMISSION HOUR	Required	Enter the 2-digit hour the participant was admitted for inpatient in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims.
14	ADMISSION TYPE	Not Required,	Admission Type: Use the priority admission codes in the *UB-04 Manual*. Only codes **1**, **2**, **3**, and **4** are allowed by Medicaid. Required for inpatient claims only.
15	ADMISSION SRC	Not Required	Admission Source: Use the 1-digit source of admission codes **1** through **8** in the *UB-04 manual*. Medicaid does not accept code **9**. Required for inpatient claims only.
16	DHR	Not Required	Discharge Hour: Enter the 2-digit hour the participant was discharged in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims.

Field	Field Name	Use	Description
17	STAT	Required	Patient Status: Use one of the codes listed in *Section 3.2.8 Participant Status Codes*, to indicate patient status. Required for inpatient and Nursing Home claims.
18-28	CONDITION CODES	Desired	Use the codes listed in the NUBC billing manual.
31-34	OCCURRENCE CODE/DATE	Desired	Use one of the codes listed in the NUBC billing manual and enter the date of the occurrence.
35-36	OCCURRENCE SPAN	Desired	Use the date span related to the, Occurrence Code, entered in the preceding field.
39-41	VALUE CODES AMOUNT	Required for NH Claims if there is patient liability	Value Codes and Amounts: **31** – Patient Liability/Liability amount
42	REV. CD.	Required	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. Payable revenue codes for Nursing Home claims are listed in *Section 3.2.3 Long-Term Revenue Codes.* **Revenue code 001** is no longer to be used for the total charges; the total charges are to be entered in the designated box on line **23**.
45	SERV. DATE	Required	Enter the specific, From date of service for revenue code **100** and the units/days If billing LOA revenue code enter the From date of service for the first LOA date and the LOA units/days 1. Resubmit all denied charges on a new claim. 2. If billing for LOA days not previously billed on original claim, the original claim will need to be voided.
46	SERV. UNITS	Required	Units of Service: Enter the total number of covered days Units of service for covered days and/or LOA days must correlate accurately to the service rendered. Example: Covered Days 31 Detail From DOS 01/01/2008: Revenue code 100: Units 10 Detail From DOS 01/11/2008: Revenue code 183: Units 3 Detail From DOS 01/14/2008: Revenue code 100 Units 19
47	TOTAL CHARGES	Required	Total charges: Bill total covered charges only. Accommodation Rate Formula: Daily Rate X Units of Service Total Charges
In fields **50** through **62**, each field has three lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one other payer in addition to Medicaid, enter all primary payer data on line A and all Medicaid data on line B. If there are two other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer data on line B, and all Medicaid data on line C.			
50 A-C	PAYER NAME	Not Required	Payer A: If Medicaid is the only payer, enter *Idaho Medicaid* in field **50A**. If there is one other payer in addition to Medicaid, enter the name of the group or plan in field **50A** and enter *Idaho Medicaid* in field **50B**.

Field	Field Name	Use	Description
51 A-C	HEALTH PLAN ID	Not Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in field **50 A-C**. Example: In field **50A**, Medicare is entered as the Payer. In field **51A**, enter the identification number used by Medicare for the provider. Example: In field **50B**, Healthy Home Insurance Company is entered as the Payer. In field **51B** enter the identification number used by Healthy Home Insurance Company for the provider.
54	PRIOR PAYMENTS	Required, If Applicable	Prior Payments - Payers and Participant: Required if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do not include previous Medicaid payments.
55	EST. AMOUNT DUE	Not Required	Estimated Amount Due: Total charges due (total from field **47**) minus prior payments (total from field **54**).
57 A-C	OTHER (BILLING) PRV ID	Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in field **50 A-C**. Example: In field **50A**, Medicare is entered as the Payer. In field **57A**, enter the identification number used by Medicare for the provider. Example: In field **50B**, Healthy Home Insurance Company is entered as the Payer. In field **57B** enter the identification number used by Healthy Home Insurance Company for the provider.
58	INSURED'S NAME	Desired	Insured's Name: If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial. Enter the participant Medicaid data in the same line used to enter the Medicaid provider data. Example: Medicaid provider information is entered in **50A**, and then the Medicaid participant data must be entered in **58A**.
59	P. REL	Desired	Participant's Relationship to Insured: See the *UB-04 Manual* for the 2-digit relationship codes.
60	INSURED'S UNIQUE ID	Not Required	Participant Identification Number: Enter the 7-digit MID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).
61	GROUP NAME	Not Required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	INSURANCE GROUP NO.	Not Required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORIZ-ATION CODES	Required, If Applicable	Treatment Authorization Codes: PA number for AND, or retrospective reviews or PA number for ambulance run by EMS.
67	DX A-Q	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. Do not use E diagnosis codes.

Field	Field Name	Use	Description
68-73	OTHER DX	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. Do **not** use E diagnosis codes.
69	ADMIT DX	Required	Admitting Diagnosis Code: Required for inpatient. Desired for outpatient claims. Quality Improvement Organization (QIO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the *Qualis Health Manual*.
72	ECI	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the CMS-1500 claim form for professional claims.)
74	PRINCIPAL PROCEDURE CODE/DATE	Not Required	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical, diagnostic or obstetrical procedure. Procedure date is required if procedure code is used.
74 a-e	OTHER PROCEDURE CODE/DATE	Not Required	Other Procedure Codes and Dates: Enter all secondary surgical, diagnostic or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
76	ATTENDING	Required	Attending Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (last) box after, **76** Attending. Inpatient: Enter the Idaho Medicaid provider number for the physician attending the patient. This is the physician primarily responsible for the care of the participant from the beginning of this hospitalization. Outpatient: Enter the Idaho Medicaid provider number for the physician referring the participant to the hospital.

3.3.3.4 Sample Paper Claim Form